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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LISA ANN NICHOLSON** **aka LISA ANN CANN** 118 Fallon Lane Sacramento, California 95819 **Registered Nurse License No. 623697** Respondent.	Case No. 2010-650 **A C C U S A T I O N**

Louise R. Bailey, M.Ed. RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 8, 2003, the Board issued Registered Nurse License Number 623697, to Lisa Ann Nicholson, also known as Lisa Ann Cann ("Respondent"). The license expired on June 30, 2009, and has not been renewed.

JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

5. Code section 2761(a) states, in pertinent part, that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

6. Code section 2762 states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Code section 2770.7 states, in pertinent part:

> (c) If the reasons for a current investigation of a registered nurse are based primarily on the self-administration of any controlled substance or dangerous drug or alcohol under Section 2762, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drug for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the registered nurse is accepted into the board's diversion program and successfully completes the requirements of the program. If the registered nurse withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

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(d) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any registered nurse for any unprofessional conduct committed before, during, or after participation in the diversion program.

. . . .

(f) Any registered nurse terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the diversion program. A registered nurse who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

8. Code section 2770.11(b) states:

If a committee determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the committee shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

9. Code section 4060 states:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse- midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

10. Health and Safety Code section 11173(a) states:

No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

COST RECOVERY

11. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

Controlled Substances at Issue

12. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).

13. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(K).

14. "Oxycodone" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(N).

15. "Lorazepam" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(13).

16. "Methadone" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(14).

RESPONDENT'S TERMINATION FROM THE BOARD'S DIVERSION PROGRAM AS A PUBLIC RISK

17. On or about April 19, 2007, Respondent was enrolled in the Board's Diversion Program. On or about February 19, 2008, the Diversion Evaluation Committee ("DEC") terminated Respondent from the Diversion Program for noncompliance/public risk for missing Nurse Support Group meetings, receiving opiates for various medical conditions, having little contact with MAXIMUS, and missing two scheduled drug tests, pursuant to Code section 2770.11.

FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries in Hospital or Patient Records)

18. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(e), in that between November 19, 2006, and January 22, 2007, while a registered nurse in the Intensive Care Unit at Kaiser Permanente, located in Sacramento, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

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Patient A/B (same patient):

a. On or about January 7, 2007, at 1910 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone, but failed to account for the disposition of the Hydromorphone in any hospital or patient record.

b. On or about January 7, 2007, at 2036 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1.5 mg. of Hydromorphone, but failed to account for the remaining .5 mg. in any hospital or patient record.

c. On or about January 7, 2007, at 2312 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 2300 hours, and documented wasting 1 mg., but failed to account for the remaining .5 mg. of Hydromorphone in any hospital or patient record.

d. On or about January 8, 2007, at 0046 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 0100 hours, and documented wasting 1 mg., but failed to account for the remaining .5 mg. of Hydromorphone in any hospital or patient record.

e. On or about January 8, 2007, at 0454 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1.5 mg. of Hydromorphone, but failed to account for the remaining .5 mg. in any hospital or patient record.

f. On or about January 8, 2007, at 0605 hours, Respondent signed out one (1) 2 mg. syringe of Lorazepam. Respondent charted the administration of 1 mg. of Lorazepam at 0633 hours, and documented wasting 1 mg. However, the administration of Lorazepam was inconsistent with physician's orders, which called for the administration of Lorazepam every four (4) hours, in that Respondent had administered 1 mg. of Lorazepam at 0300 hours (3 hours and 33 minutes earlier).

Patient C:

g. On or about January 21, 2007, at 1908 hours, Respondent signed out one (1) 2 mg. syringe of Lorazepam without a physician's order. Respondent charted the administration of .5 mg. of Lorazepam at 1908 hours, and documented wasting 1.5 mg.

h. On or about January 21, 2007, at 2025 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 2025 hours and documented wasting 1.5 mg. However, the administration of Hydromorphone was inconsistent with physician's orders, which called for the administration of Hydromorphone every two (2) hours, in that Respondent had administered .5 mg. of Hydromorphone at 1918 hours (1 hour and 27 minutes earlier).

i. On or about January 21, 2007, at 2138 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 2105 hours, and documented wasting 1 mg., but failed to account for the remaining .5 mg. of Hydromorphone in any hospital or patient record. In addition, the administration of Hydromorphone was inconsistent with physician's orders, which called for the administration of Hydromorphone every two (2) hours, in that Respondent had administered .5 mg. of Hydromorphone at 2025 hours (40 minutes earlier).

j. On or about January 21, 2007, at 2315 hours, Respondent charted the administration of 1 mg. of Hydromorphone. However, the records do not reflect a withdrawal of Hydromorphone at that time.

k. On or about January 22, 2007, at 0544 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of 1 mg. of Hydromorphone at 0544 hours, and documented wasting 1 mg. However, the administration of Hydromorphone was inconsistent with physician's orders, which called for the administration of Hydromorphone every two (2) hours, in that Respondent had administered 1 mg. of Hydromorphone at 0420 hours (1 hour and 22 minutes earlier).

Patient D:

l. On or about January 13, 2007, at 1936 hours, Respondent signed out two (2) 2 mg. injectables of Hydromorphone without a physician's order, and failed to account for the disposition of the Hydromorphone in any hospital or patient record.

m. On or about January 13, 2007, at 2336 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone without a physician's order. Respondent documented wasting 1

mg. of Hydromorphone, but failed to account for the remaining 1 mg. in any hospital or patient record.

n. On or about January 14, 2007, at 0126 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone without a physician's order. Respondent documented wasting 1.5 mg. of Hydromorphone, but failed to account for the remaining .5 mg. in any hospital or patient record.

o. On or about January 14, 2007, at 0434 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone without a physician's order. Respondent documented wasting 1.5 mg. of Hydromorphone, but failed to account for the remaining .5 mg. in any hospital or patient record.

Patient E:

p. On or about January 2, 2007, at 0123 hours, Respondent signed out one (1) 2 mg. syringe of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.

Patient F:

q. On or about January 15, 2007, at 1938 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 1938 hours, but failed to account for the disposition of the remaining 1.5 mg. in any hospital or patient record.

r. On or about January 15, 2007, at 1959 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 2000 hours, but failed to account for the disposition of the remaining 1.5 mg. in any hospital or patient record.

s. On or about January 15, 2007, at 2130 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1 mg. of Hydromorphone, but failed to account for the remaining 1 mg. in any hospital or patient record.

t. On or about January 15, 2007, at 2236 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of

Hydromorphone at 2236 hours, but failed to account for the remaining 1.5 mg. in any hospital or patient record.

u. On or about January 15, 2007, at 2312 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1 mg. of Hydromorphone, but failed to account for the remaining 1 mg. in any hospital or patient record.

v. On or about January 16, 2007, at 0006 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 0006 hours, and documented wasting 1 mg., but failed to account for the remaining .5 mg. of Hydromorphone in any hospital or patient record.

w. On or about January 16, 2007, at 0051 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone, but failed to account for the disposition of the Hydromorphone in any hospital or patient record.

x. On or about January 16, 2007, at 0342 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 0340 hours, but failed to account for the remaining 1.5 mg. in any hospital or patient record.

y. On or about January 16, 2007, at 0433 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 0433 hours, but failed to account for the remaining 1.5 mg. in any hospital or patient record.

z. On or about January 16, 2007, at 0607 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of 1 mg. of Hydromorphone at 0607 hours, but failed to account for the remaining 1 mg. in any hospital or patient record.

aa. On or about January 16, 2007, at 0632 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1 mg. of Hydromorphone, but failed to account for the remaining 1 mg. in any hospital or patient record.

bb. On or about January 16, 2007, at 1939 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone, but failed to account for the disposition of the Hydromorphone in any hospital or patient record.

cc. On or about January 16, 2007, at 2038 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted wasting 1 mg. of Hydromorphone, but failed to account for the remaining 1 mg. in any hospital or patient record.

dd. On or about January 16, 2007, at 2040 hours, Respondent signed out one (1) 30 mg. tablet of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.

ee. On or about January 16, 2007, at 2222 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted wasting 1 mg. of Hydromorphone, but failed to account for the remaining 1 mg. in any hospital or patient record.

Patient III:

ff. On or about November 20, 2006, at 2040 hours, Respondent signed out two (2) 2 mg. syringes of Morphine, but failed to account for the Morphine in any hospital or patient record.

gg. On or about November 20, 2006, at 2114 hours, Respondent signed out two (2) 2 mg. syringes of Morphine. Respondent charted the administration of 4 mg. of Morphine at 2157 hours. However, the administration of Morphine was inconsistent with physician's orders, which called for the administration of 2 mg. of Morphine every 5 minutes, in that Respondent had administered 2 mg. of Morphine at 2155 hours (3 minutes earlier).

hh. On or about November 20, 2006, at 2345 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone without a physician's order, and failed to account for the disposition of the Hydromorphone in any hospital or patient record.

ii. On or about November 21, 2006, at 0057 hours, Respondent signed out two (2) 2 mg. syringes of Morphine. Respondent charted the administration of 4 mg. at 0010 hours. However, the administration of Morphine was inconsistent with physician's orders, which called for the administration of 2 mg. of Morphine.

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Patient IV:

jj. On or about November 18, 2006, at 2351 hours, Respondent signed out two (2) tablets of Oxycodone. Respondent charted the administration of one tablet at 2316 hours, but failed to account for the one remaining tablet of Oxycodone in any hospital or patient record.

kk. On or about November 19, 2006, at 0612 hours, Respondent signed out two (2) tablets of Oxycodone. Respondent charted the administration of two tables of Oxycodone at 0615 hours, which was inconsistent with physician's orders that called for the administration of two tablets every four hours, in that Respondent had administered two tablets of Oxycodone at 0255 hours (3 hours and 17 minutes earlier).

Patient V:

ll. On or about December 10, 2006, at 1906 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .25 mg. of Hydromorphone at 1926 hours, but failed to account for the remaining 1.75 mg. in any hospital or patient record.

mm. On or about December 10, 2006, at 1940 hours, Respondent charted the administration of .5 mg. of Hydromorphone. However, the records do not reflect a withdrawal of Hydromorphone at that time.

nn. On or about December 10, 2006, at 2012 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .75 mg. of Hydromorphone at 2040 hours, but failed to account for the remaining 1.25 mg. in any hospital or patient record.

oo. On or about December 10, 2006, at 2200 hours, Respondent charted the administration of .75 mg. of Hydromorphone. However, the records do not reflect a withdrawal of Hydromorphone at that time.

pp. On or about December 10, 2006, at 2304 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1.5 mg. of Hydromorphone, but failed to account for the remaining .5 mg. in any hospital or patient record.

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qq. On or about December 10, 2006, at 2354 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .75 mg. at 0000 hours, but failed to account for the remaining 1.25 mg. of Hydromorphone in any hospital or patient record.

rr. On or about December 11, 2006, at 0225 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .75 mg. at 0200 hours, but failed to account for the remaining 1.25 mg. of Hydromorphone in any hospital or patient record.

ss. On or about December 11, 2006, at 0400 hours, Respondent charted the administration of .75 mg. of Hydromorphone. However, the records do not reflect a withdrawal of Hydromorphone at that time.

tt. On or about December 11, 2006, at 0535 hours, Respondent signed out one (1) tablet of Oxycodone. Respondent charted the administration of one tablet of Oxycodone at 0630 hours, which is inconsistent with physician's orders that call for the administration of one tablet every four hours, in that Respondent had administered one tablet of Oxycodone at 0300 hours (3 hours and 30 minutes earlier).

uu. On or about December 11, 2006, at 0535 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .75 mg. at 0600 hours, but failed to account for the remaining 1.25 mg. of Hydromorphone in any hospital or patient record.

vv. On or about December 11, 2006, at 0624 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1.25 mg. of Hydromorphone, but failed to account for the remaining .75 mg. in any hospital or patient record.

Patient VII:

ww. On or about November 23, 2006, at 1930 hours, Respondent charted the administration of .5 mg. of Hydromorphone. However, the records do not reflect a withdrawal of Hydromorphone at that time.

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xx. On or about November 23, 2006, at 2005 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone at 2110 hours, but failed to account for the remaining 1.5 mg. of Hydromorphone in any hospital or patient record.

yy. On or about November 23, 2006, at 2006 hours, Respondent signed out one (1) 10 mg. Methadone tablet without a physician's order, and failed to account for the disposition of the Methadone in any hospital or patient record.

zz. On or about November 23, 2006, at 2300 hours, Respondent charted the administration of .5 mg. of Hydromorphone. However, the records do not reflect a withdrawal of Hydromorphone at that time.

aaa. On or about November 24, 2006, at 0217 hours, Respondent signed out (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. of Hydromorphone, but failed to account for the remaining 1.5 mg. in any hospital or patient record.

bbb. On or about November 24, 2006, at 0400 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting .5 mg. of Hydromorphone, but failed to account for the remaining 1.5 mg. in any hospital or patient record.

ccc. On or about November 24, 2006, at 0620 hours, Respondent signed out one (1) 10 mg. tablet of Methadone without a physician's order. Respondent charted wasting 5 mg., but failed to account for the remaining 5 mg. of Methadone in any hospital or patient record.

ddd. On or about November 24, 2006, at 0621 hours, Respondent charted the administration of .5 mg. of Hydromorphone. However, the records do not reflect a withdrawal of Hydromorphone at this time.

eee. On or about November 24, 2006, at 0626 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting .5 mg. of Hydromorphone, but failed to account for the remaining 1.5 mg. in any hospital or patient record.

fff. On or about November 24, 2006, at 0651 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone, but failed to account for the Hydromorphone in any hospital or patient record.

ggg. On or about November 24, 2006, at 0859 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent charted the administration of .5 mg. at 0800 hours, but failed to account for the remaining 1.5 mg. of Hydromorphone in any hospital or patient record.

hhh. On or about November 24, 2006, at 1109 hours, Respondent signed out one (1) 2 mg. injectable of Hydromorphone. Respondent documented wasting 1 mg. of Hydromorphone, but failed to account for the remaining 1 mg. in any hospital or patient record.

SECOND CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances)

19. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(a), in that:

a. Between November 20, 2006 through January 16, 2010, while a registered nurse in the Intensive Care Unit at Kaiser Permanente, located in Sacramento, California, Respondent obtained controlled substances by fraud, deceit, misrepresentation or subterfuge or by the concealment of a material fact in violation of Health and Safety Code section 11173(a), by removing medication from the Pyxis machine without a physician's order, and by failing to administer medications per physician's orders, as more particularly set forth above in paragraph 18, above.

b. Respondent possessed Lorazepam, Hydromorphone, and Methadone, controlled substances, in violation of Code section 4060, in that she did not have a prescription for those controlled substances.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 623697, issued to Lisa Ann Nicholson, also known as Lisa Ann Cann;

2. Ordering Lisa Ann Nicholson, also known as Lisa Ann Cann to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/17/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., R.N.
Interim Executive Officer
Board of Registered Nursing
State of California
Complainant

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